Best Practices for Documenting the SUD Encounter

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Financial Disclosures

The following session leader has no relevant Financial relationships with ineligible companies to disclose:

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Learning Objectives

- Describe and provide examples of key documentation elements in the SUD Encounter.

Clinical Documentation Best Practices

Why is quality documentation important?

- Support in the Continuum of Care – Communication / Care Plans
- Billing / Financial Impacts
- Legal Implications
- Regulatory
- Continuous Improvement – (Process, Outcomes)

Characteristics of Quality Documentation:

Legible: Information should be able to be read and the reader should easily comprehend what is documented.

Clear: Documentation should not be vague. It should fully describe the patient issue without being open to interpretation.

Complete: Documentation should address the patient's issues and/or concerns from a diagnostic perspective with proper authentication by the provider (signature and date).

Consistent: Documentation should not conflict between the providers and/or from one progress note to another.

Accurate/Precise: The more detail a provider documents in the health record, the more information will be available to ensure the accuracy of the clinical documentation in the health record.

Reliable: The treatment plan should be supported by the provider documentation

Timely: Timeliness of clinical documentation entries increases the opportunity to provide the best care and treatment

Progress Note- SOAP Format

•Subjective- Information obtained from the patient including medical, surgical, social histories, medications/allergies

•Objective- Vital signs and physical examination findings

•Assessment- Appropriate diagnoses with ICD-10 codes

•Plan- Medical Decision Making, Medication adjustments, Referrals, Follow up frequency.

Patient Intake Form

ROWAN UNIVERSITY School of Osteopathic Medicine

NMI
NeuroMusculoskeletal Institute

Patient Name: _____

Date of Birth: _____

Today's Date: _____

ESTABLISHED PATIENT QUESTIONAIRE- addiction medicine

HISTORY

Are you taking all your medications as prescribed?

If not, why? _____

Have you used any substances or Alcohol (legal or illegal) that were not prescribed to you since your last visit? (Y/N)

If yes, what and when?

_____

Do you have physical cravings to use other medications of illicit substances? (Y/N) Describe:

_____

_____

_____

Are you going to AA/NA meetings and how often?

_____ Have you obtained a sponsor? (Y / N)

Do you have a private therapist? (Y / N) If yes, who? _____

Describe any other changes in your Medical, Family or Social history since your last visit:

_____

_____

_____

Patient Intake Form

List Any Changes in Your Current Medications (Since Your Last Office Visit):

☐ Check here if there are no changes from previous visit

Medication	Dose	# per day	Effect	Problems

Review of Systems (Check all that apply)

☐ Fatigue	☐ Nausea	☐ Dizziness	☐ Night Sweats
☐ Vision changes	☐ Vomiting	☐ Numbness	☐ Easy Bruising
☐ Trouble swallowing	☐ Constipation	☐ Lightheaded	☐ Seasonal Allergies
☐ Chest Pain	☐ Bowel Incontinence	☐ Depression	OTHER (list):
☐ Leg Swelling	☐ Bladder Incontinence	☐ Anxiety	
☐ Trouble Breathing	☐ Muscle Spasm	☐ Rashes	

Patient Intake Form

ROWAN UNIVERSITY School of Osteopathic Medicine

NMI

NeuroMusculoskeletal Institute

Patient Name: _____

Date of Birth: _____

Today's Date: _____

If you also have pain complaints complete below

Where is your pain located? _____

Since your last office visit, is your pain: BETTER WORSE NO DIFFERENT?

Did you have a procedure since your last office visit? ☐ NO ☐ YES

If yes, what procedure? _____

SINCE YOUR LAST OFFICE VISIT:

What is the current level of your pain? (Mark below)

no pain 5 extreme pain

0 ——|——|——|——|——|——|——|——|——|——|—— 10

What is your BEST level of pain? (Mark below)

no pain 5 extreme pain

0 ——|——|——|——|——|——|——|——|——|——|—— 10

What is the WORST level of your pain? (Mark below)

no pain 5 extreme pain

0 ——|——|——|——|——|——|——|——|——|——|—— 10

Any radiation of pain? ☐ NO ☐ YES

If yes, where? _____

Any numbness or tingling? ☐ NO ☐ YES

If yes, where? _____

Describe your pain (Check all that apply):

☐ Sharp ☐ Burning ☐ Aching ☐ Shooting ☐ Deep
☐ Knife-Like ☐ Electric ☐ Heavy ☐ Lacerating

Patient Intake Form

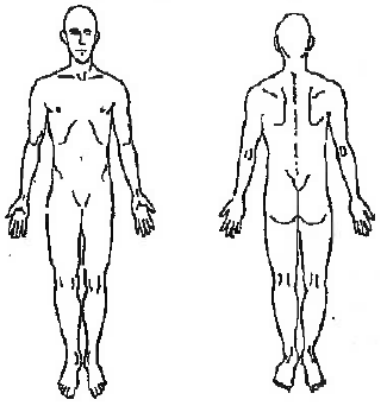
What makes your pain better? _____

What makes your pain worse? _____

When during the day do you have pain?

☐ Morning ☐ Afternoon ☐ Evening ☐ All Day

☐ Other _____



Mark any areas affected with symbols

Stabbing	///	Numb	═══
Ache	AAA	Burning	xxx
		Pins & Needles	ooo

_____

Patient Signature

PHYSICIAN NOTES

☐ All Systems Negative (ROS)/Reviewed with Patient

☐ Reviewed with Patient

_____ _____

Attending Signature Date

Buprenorphine/Naloxone Maintenance Treatment
Intake Questionnaire for Patient Treatment-Planning Questions

Name:_____ **Date:**_____

Please answer the following questions which will help us design your plan of treatment:

What is the best time of day and day of week for you for clinic visits?

Are there any months of the year when you may have difficulty making it in for appointments?

Is there any problem that makes it hard for you to give routine urine specimens?

Do you have any disabilities that make it hard for you to read labels or count pills?

What are your reasons for being interested in Buprenorphine/Naloxone treatment?

What "triggers" do you know which have put you in danger or relapse in the past or which might in the future?

https://pcssnow.org/wp-content/uploads/2015/03/Sample-intake-questionnaire.pdf

What coping methods have you developed to deal with these triggers to relapse?

What plans do you have for the coming year?

Work?_____

Home?_____

Other?_____

What kinds of help would you like from your counselor?

What are your strengths and skills to handle take-home Buprenorphine/Naloxone (Suboxone)?

What worries do you have about extended take homes?

Is anyone in your home actively addicted to drugs or alcohol?

What are the major sources of stress in your life?

What family or significant others will be supportive to you during your treatment?

Would you be willing to sign a release so that the person(s) identified above can be spoken to regarding your treatment?

What medical care will you have in the coming year?

How will you comply with the annual physical examination and laboratory and urine testing requirements?

Have you ever been treated for a psychiatric problem or mental illness or prescribed psychiatric medications?

https://pcssnow.org/wp-content/uploads/2015/03/Sample-intake-questionnaire.pdf

Rapid Urine Drug Screen

•Given patient's history of high-risk medication use or illicit drug use a rapid 14 panel urine toxicology was performed. The following were positive and the cup will be sent out for confirmatory quantification. A separate FTL dip was also obtained. All CLIA-waived products.

- •THC
- •COC
- •MOP
- •MET
- •AMP
- •BZO
- •BAR
- •MTD
- BUP
- TCA
- MDMA
- OXY
- PCP
- PPX
- FTL
- All others negative

History of Present Illness: ASAM Criteria

•In addition to the standard H&P, these should be incorporated

1. Acute intoxication and withdrawal potential
2. Biomedical conditions and complications
3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to change
5. Relapse or continued use or continued problem potential
6. Recovery environment

Buprenorphine Treatment
Intake History and Physical

Name: _____ **DOB:** _____ **Date:** _____

Chief Complaint: _____

***Opiate use history*:**
Type of opiates_____Route_____Current Amount/Freq_____
Current length of continuous use_____Yrs/mos of use_____
Present symptoms
_____
_____
History of substance use disorder treatment (outpatient/inpatient/residential)
_____
History of: Methadone_____ Naltrexone-XR_____ Buprenorphine_____ Overdose _____

Other drug abuse history:
- ☐ Cocaine/stimulant: Route:____ Current amount:_____ Mos/Yrs of Use:_____ Last Use:_____
  Complications of Use: _____
- ☐ Alcohol: Current amount:_____Mos/Yrs of Use:_____ Last Use:_____
  Complications of Use:_____
- ☐ Benzodiazepines: Route:____ Current amount:_____ Mos/Yrs of Use:_____ Last Use:_____
  Complications of Use:_____
- ☐ Cannabis: Route:_____ Current amount:_____ Mos/Yrs of Use:_____ Last Use:_____
  Complications of Use:_____
- ☐ Nicotine/cigarettes: Current amount: _____ Pack years_____
- ☐ Other:

***Medical history*:**
Medical/psychiatric problems
_____
Hospitalizations/surgeries
_____
Psychiatric treatment
_____

Allergies_____ Current meds_____

Hepatitis_____ SBE _____ HIV _____ TB _____ STD _____
(women) LMP_____ G___ P___ TAB___ SAB___ Contraception_____
ROS: _____
_____

Routine screening history (pap, chol, TB, Hep Panel, HIV, ECG, Pregnancy test, etc.):
_____

Buprenorphine Treatment
Intake History and Physical (continued)

Physical Examination:

T____ P____ BP_____ R____ WT_____ HT_____ Gen. Appearance_____

HEENT
_____
Thyroid/neck
_____
Heart
_____
Lungs
_____
Chest/breast
_____

ABD_____
Neuro_____
Extrem_____
Skin _____
Tracks/scars_____

Signs of Opioid Withdrawal:

Time of last use: _____

- ☐ Pupillary dilation
- ☐ Rhinorrhea
- ☐ Lacrimation
- ☐ Diaphoresis
- ☐ Pilorection
- ☐ Increase temp.
- ☐ Increase BP
- ☐ Tachycardia
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Diarrhea
- ☐ Myalgia/Joint Pain
- ☐ Restlessness
- ☐ Anxiety
- ☐ Yawning
- ☐ Tremor
- ☐ Goosebumps

COWS Score_____

Screening Laboratory Results:
Urine Drug Screen Results: _____
Liver function Test Results: _____
Other Labs (CBC, chemistries): _____

Assessment and Plan:

Opioid Use Disorder: mild___ moderate___ severe___ not present___

withdrawal degree: none___ minimal___ moderate___ severe___

https://pcssnow.org/wp-content/uploads/2021/12/Sample-Medical-History-and-PE-Form_2021.pdf

Other Diagnoses: _____

_____

_____

Buprenorphine Treatment
Intake History and Physical (continued)

Initial Treatment Plan:

_____

_____

_____

Screening for Appropriateness for Buprenorphine Treatment:

_____

_____

_____

Initial Orders:

Laboratory testing:

- ☐ CBC
- ☐ Chem Panel
- ☐ Urine Drug Screen (expanded panel for opioids)
- ☐ other: Hepatitis Panel _____HIV antibody _____Pregnancy Test (Urine/Serum)____ECG____
- ☐ Breathalyzer
- ☐ TB test: placed date_____ to be read date _____

Admit to buprenorphine maintenance/medical withdrawal treatment. Induction instructions and treatment contract given to patient.

Induction dose orders: _____

Urine drug screen schedule: _____

Counseling plans: _____

Next visit: _____

Maintenance Buprenorphine/Naloxone Dose: _____

Signed _____ Date _____

Documenting Severity of SUD

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DSM-5 Criteria for Diagnosis of Opioid Use Disorder

Diagnostic Criteria*
These criteria not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Check all that apply

	Opioids are often taken in larger amounts or over a longer period of time than intended.
	There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
	Craving, or a strong desire to use opioids.
	Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
	Important social, occupational or recreational activities are given up or reduced because of opioid use.
	Recurrent opioid use in situations in which it is physically hazardous
	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
	*Tolerance, as defined by either of the following: (a) a need for markedly increased amounts of opioids to achieve intoxication or desired effect (b) markedly diminished effect with continued use of the same amount of an opioid
	*Withdrawal, as manifested by either of the following: (a) the characteristic opioid withdrawal syndrome (b) the same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms

Total Number Boxes Checked: _____

Severity: **Mild**: 2-3 symptoms. **Moderate**: 4-5 symptoms. **Severe**: 6 or more symptoms

*Criteria from American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,. Washington, DC, American Psychiatric Association page 541. For use outside of IT MATTTRs Colorado, please contact ITMATTTRsColorado@ucdenver.edu

https://www.addictionpolicy.org/post/dsm-5-facts-and-figures#:~:text=Three%20Levels%20of%20Severity&text=Two%20or%20three%20symptoms%20indicate,known%20as%20having%20an%20addiction.

Assessment and Plan

- "Patient meets criteria for current or past opioid use disorder. Pt was counseled as to safe keeping of medications and not to give to others. Pt will be monitored with PMP quarterly and rapid UDS done at every visit. Patient has signed a Suboxone agreement. They may be referred to AA, NA, or private treatment if appropriate for their stage of recovery."

- Plan
  - Address SUD and frequency of visits
  - Referrals as needed to primary care, ID, Psych, NA/AA, or elevated level of care
  - Address/consider chronic medical conditions and workup as needed
  - Patient meets with patient navigator for scheduling and with social worker/peer coach prior to leaving office.

Categories of Symptoms

CATEGORIES OF SUD SYMPTOMS

Symptoms of substance use disorders in the DSM 5 fall into four categories: 1) impaired control; 2) social problems; 3) risky use, and 4) physical dependence.

Impaired Control	Social Problems	Risky Use	Physical Dependence
Using more of a substance or more often than intended Wanting to cut down or stop using but not being able to	Neglecting responsibilities and relationships Giving up activities they used to care about because of their substance use Inability to complete tasks at home, school or work	Using in risky settings Continued use despite known problems	Needing more of the substance to get the same effect (tolerance) Having withdrawal symptoms when a substance isn't used

References

1. Hess, Pamela Carroll. Clinical Documentation Improvement: Principles and Practice. Chicago: AHIMA Press, 2017

2. Edelman, E. J., Oldfield, B. J., & Tetrault, J. M. (2018). Office-Based Addiction Treatment in Primary Care: Approaches That Work. *Medical Clinics of North America, 102*(4), 635-652. https://doi.org/10.1016/j.mcna.2018.02.007

3. *Office Based Addiction Treatment Training and Technical Assistance.* https://www.bmcobat.org/resources/index.php?filename=22_2021_Clinical_Guidelines_1.12.2022_fp_th%2528003%2529.29.pdf

4. Tunney, S.*NJ MATrx Model.* https://www.nj.gov/humanservices/dmhas/information/provider/Provider_Meetings/2019/MAAC%20OBAT.pdf

5. https://pcssnow.org/

Thank you!
Questions & Discussion